Welcome! Thank you for choosing our practice for your health needs. Your first visit to our center is an opportunity for us to learn all about you. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Child's Information

Child's Name ____ Birth Date _____/_____/_____ Age___________

Mother's Name ____

Father's Name____

Phone: Home ____________________________________ Cell ____________________________________

Email Address ____

Preferred method for appointment reminders: ❑ Email ❑ Text If Text - Cell phone provider____________________

Address ____
Number & Street City State Zip

How did you hear about us? _______________________________________

Health History

Has your child ever been to a chiropractor before? ❑ Yes ❑ No If yes, how long has it been?___________________

Were you happy with their care? ❑ Yes ❑ No Explain____
____

Has your child ever been told they have any problems/defects in their spine or nerve system? ❑ Yes ❑ No

If yes, what? ____

List any surgeries and the dates which they occurred, if any: ____
____

List any medications your child currently takes, if any: ____
____

Were there any complications in the pregnancy or delivery of your child? ❑ Yes ❑ No
If yes, please explain____
____

Was your child born by C-Section? ❑ Yes ❑ No

How long was the actual labor and delivery time?____

Did the doctor use forceps or other devices for delivery? ❑ Yes ❑ No

How Can We Help You?

What is the main reason for your child's visit today? ____
____
____

Any other specific reasons or concerns?____
____
____

Symptoms are our body's way of telling us something is wrong with our health. Please check off anything that your child is **currently experiencing** or has experienced **in the last 6 months**:

❑Headaches	❑Dizziness	❑Fatigue	❑Depression
❑Sore Throat	❑Neck Discomfort	❑Low Back Discomfort	❑Mid-back Discomfort
❑Frequent Colds	❑Ear Aches	❑Hand/Arm Numbness	❑Leg/Foot Numbness
❑Sinus Problems	❑Anxiety	❑Fainting	❑Bed Wetting
❑Gas/Bloating	❑Nausea	❑Heartburn	❑Ulcers
❑Diarrhea	❑Constipation	❑Colitis	❑IBS
❑Gall Bladder	❑Walking Problems	❑Shoulder Problems	❑Convulsions
❑Difficulty Concentrating	❑Asthma	❑Allergies	❑Short breath
❑Chest Congestion	❑Lung Problems	❑Thyroid Problems	❑Diabetes
❑Cancer	❑Liver Problems	❑Kidney Problems	❑Blood Problems
❑Extremity Weakness	❑Extremity Swelling	❑Cold Extremities	❑Bladder Problems

Are there any other health problems that concern you?
____
____
____

How would you describe the health of your child's eating habits on a scale of 1 to 10?

Very Poor 1 2 3 4 5 6 7 8 9 10 Perfectly Healthy

Are you satisfied with how healthy they eat? Yes No

How would you describe the amount of physical activity your child engages in on a scale of 1 to 10?

None 1 2 3 4 5 6 7 8 9 10 Very Active

Are you satisfied with their activity level? Yes No

Is there anything else you feel we should know?____
____
____

Authorization for Care of Minor

I hereby authorize DiMartino Chiropractic Center and its doctors to administer chiropractic care for the treatment of conditions related to the spine for my son/daughter/ward. This includes but is not limited to physical examinations, x-rays, nutritional advice and spinal adjustments.

Signature___________________________________ Date:______________ Witnessed:____________________________

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party providers
- Conduct normal healthcare operations such as quality assessment and physician's certifications

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (printed)____

Signature____Date______________________

Minor - Parent Signature____Date_____________________

Would you like to authorize other person(s) to have access to your health records? Yes No

If yes, please state name of person(s)____

X-ray Consent

I authorize the taking of diagnostic x-rays as part of my chiropractic spinal examination with DiMartino Chiropractic Center, PC. I have been advised and understand the dangers of radiation. I verify that to the best of my knowledge, I am not pregnant, nor do I have plans for pregnancy for at least 30 days.

Patient Name (printed)____

Signature____Date________________________

Minor - Parent Signature____Date________________________

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective. Our only practice objective is to improve vertebral subluxation, a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to improve vertebral subluxations. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to express its maximum health potential.
Adjustment: An adjustment is the specific application of forces to facilitate the body's improvement of vertebral subluxation. Our method of vertebral subluxation improvement is by specific chiropractic adjustment of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination or care, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or disorder is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

All questions regarding the doctor's objective pertaining to care in this office have been answered to my satisfaction. I have read fully and understand the above statements and I accept chiropractic care on this basis.

Patient Name (printed)____

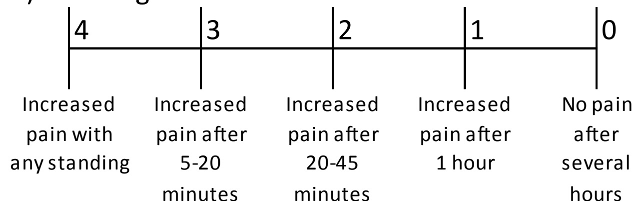
Signature____Date_____________________

Minor - Parent Signature_______________________________________Date_____________________

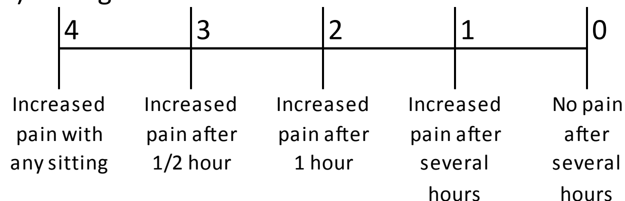
Functional Rating Index

In order to properly assess your condition, we must understand how much your neck or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

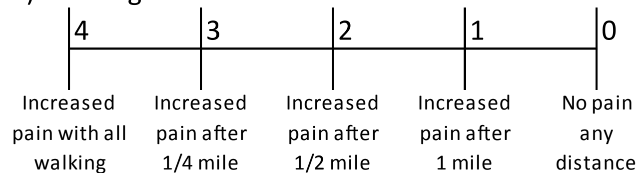
1) Standing



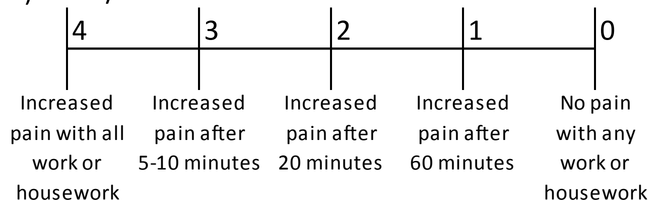
2) Sitting



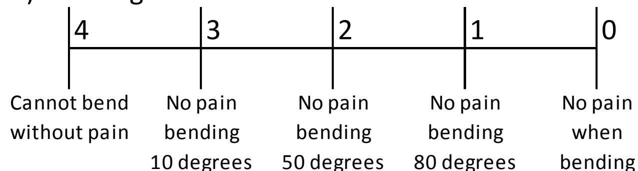
3) Walking



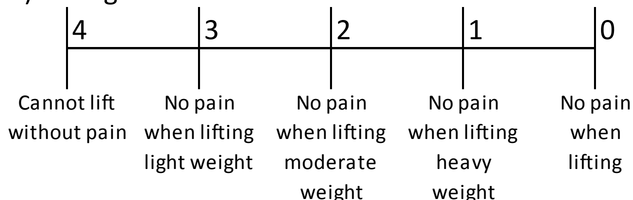
4) Work/Housework



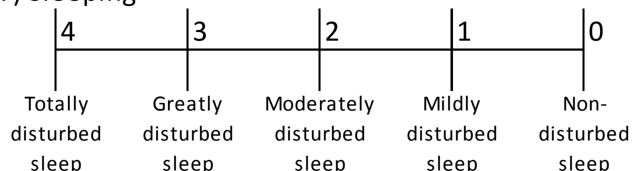
5) Bending



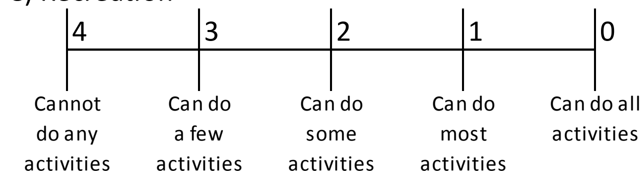
6) Lifting



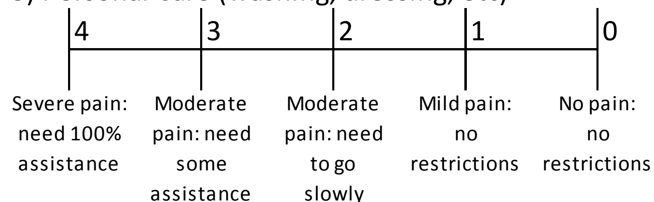
7) Sleeping



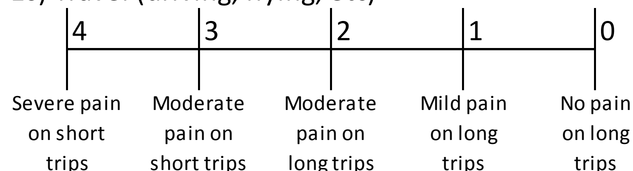
8) Recreation



9) Personal Care (washing, dressing, etc)



10) Travel (driving, flying, etc)



Total score:_______________